		FOR OHF USE					

LL1

2000
STATE OF ILLINOIS
DEPARTMENT OF PUBLIC AID
FINANCIAL AND STATISTICAL REPORT FOR
LONG-TERM CARE FACILITIES
(FISCAL YEAR 2000)

IMPORTANT NOTICE
THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE ANY INFORMATION ON OR BEFORE THE DUE DATE WILL RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

I. IDPH Facility ID Number: 0040824

Facility Name: BIRCHWOOD NURSING HOME

Address: 100 N.E. 15th Street (Number) Casey (City) 62420 (Zip Code)

County: Clark

Telephone Number: (214)932-5217 **Fax #** (217)932-5408

IDPA ID Number: 351947211001

Date of Initial License for Current Owners: 06/07/94

Type of Ownership:

	VOLUNTARY,NON-PROFIT	X	PROPRIETARY		GOVERNMENTAL
	Charitable Corp.		Individual		State
	Trust		Partnership		County
IRS Exemption Code		X	Corporation		Other
			"Sub-S" Corp.		
			Limited Liability Co.		
			Trust		
			Other		

In the event there are further questions about this report, please contact:
Name: Cathy Simeoni **Telephone Number:** (714) 596-7713 Ext. 12

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 1/1/00 to 12/31/00 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.

Officer or Administrator of Provider

(Signed) _____ (Date)
(Type or Print Name) Linda Holtzscheiter
(Title) Reimbursement Manager

Paid Preparer

(Signed) _____ (Date)
(Print Name and Title) Cathy Simeoni, Manager - Healthcare Consulting
(Firm Name & Address) Kellogg & Andelson, Accountancy Corporation
16162 Beach Blvd. #308, Huntington Beach, CA 92647
(Telephone) (714)596-7713 Fax # (714)596-7721

MAIL TO: OFFICE OF HEALTH FINANCE
ILLINOIS DEPARTMENT OF PUBLIC AID
201 S. Grand Avenue East
Springfield, IL 62763-0001 **Phone # (217) 782-1630**

Facility Name & ID Number BIRCHWOOD NURSING HOME # 0040824 Report Period Beginning: 1/1/00 Ending: 12/31/00

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days, (must agree with license). Date of change in licensed beds _____

	1 Beds at Beginning of Report Period	2 Licensure Level of Care	3 Beds at End of Report Period	4 Licensed Bed Days During Report Period	
1		Skilled (SNF)			1
2		Skilled Pediatric (SNF/PED)			2
3	75	Intermediate (ICF)	75	27,450	3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	75	TOTALS	75	27,450	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment: Public Aid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF					8
9	SNF/PED					9
10	ICF	16,638	6,367		23,005	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	16,638	6,367		23,005	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 83.81%

D. How many bed-hold days during this year were paid by Public Aid?
0 (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients.
(E.g., day care, "meals on wheels", outpatient therapy)
None

F. Does the facility maintain a daily midnight census? YES

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?
YES [X] NO [ ]

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?
YES [ ] NO [X]

I. On what date did you start providing long term care at this location?
Date started 06/07/94

J. Was the facility purchased or leased after January 1, 1978?
YES [X] Date 06/07/94 NO [ ]

K. Was the facility certified for Medicare during the reporting year?
YES [ ] NO [X] If YES, enter number of beds certified N/A and days of care provided _____

Medicare Intermediary _____

IV. ACCOUNTING BASIS

ACCRUAL [X] MODIFIED CASH* [ ] CASH* [ ]

Is your fiscal year identical to your tax year? YES [X] NO [ ]

Tax Year: 12/31 Fiscal Year: 12/31

* All facilities other than governmental must report on the accrual basis.

Facility Name & ID Number BIRCHWOOD NURSING HOME # 0040824 Report Period Beginning: 1/1/00 Ending: 12/31/00

V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger Salary/Wage 1	Supplies 2	Other 3	Total 4	Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR OHF USE ONLY 9	10	
	A. General Services											
1	Dietary	98,612	7,420	7,870	113,902		113,902		113,902			1
2	Food Purchase		91,162		91,162		91,162	(1,100)	90,062			2
3	Housekeeping	72,019	7,468		79,487		79,487		79,487			3
4	Laundry	23,664	7,359		31,023		31,023		31,023			4
5	Heat and Other Utilities			53,353	53,353		53,353		53,353			5
6	Maintenance	28,412	28,085	10,016	66,513		66,513	219	66,732			6
7	Other (specify):*											7
8	**TOTAL General Services**	222,707	141,494	71,239	435,440		435,440	(881)	434,559			8
	B. Health Care and Programs											
9	Medical Director			32,000	32,000		32,000		32,000			9
10	Nursing and Medical Records	682,241	16,178	6,537	704,956		704,956		704,956			10
10a	Therapy		15	(5,826)	(5,811)		(5,811)	5,811				10a
11	Activities	26,985	1,867		28,852		28,852		28,852			11
12	Social Services	24,220	10	4,245	28,475		28,475		28,475			12
13	Nurse Aide Training											13
14	Program Transportation											14
15	Other (specify):*											15
16	**TOTAL Health Care and Programs**	733,446	18,070	36,956	788,472		788,472	5,811	794,283			16
	C. General Administration											
17	Administrative	62,317			62,317		62,317		62,317			17
18	Directors Fees											18
19	Professional Services			4,526	4,526		4,526	7,758	12,284			19
20	Dues, Fees, Subscriptions & Promotions			4,063	4,063		4,063	145	4,208			20
21	Clerical & General Office Expenses	33,322	9,990	53,231	96,543		96,543	34,148	130,691			21
22	Employee Benefits & Payroll Taxes			154,801	154,801		154,801		154,801			22
23	Inservice Training & Education			2,383	2,383		2,383		2,383			23
24	Travel and Seminar			8,155	8,155		8,155	(1,392)	6,763			24
25	Other Admin. Staff Transportation											25
26	Insurance-Prop.Liab.Malpractice			41,144	41,144		41,144	835	41,979			26
27	Other (specify):*											27
28	**TOTAL General Administration**	95,639	9,990	268,303	373,932		373,932	41,494	415,426			28
29	**TOTAL Operating Expense (sum of lines 8, 16 & 28)**	1,051,792	169,554	376,498	1,597,844		1,597,844	46,424	1,644,268			29

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

Facility Name & ID Number BIRCHWOOD NURSING HOME #0040824 Report Period Beginning: 1/1/00 Ending: 12/31/00

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4	5	6	7	8	9	10	
	D. Ownership											
30	Depreciation			18,602	18,602		18,602	83,771	102,373			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			189,729	189,729		189,729	20,661	210,390			32
33	Real Estate Taxes			16,106	16,106		16,106		16,106			33
34	Rent-Facility & Grounds							29,641	29,641			34
35	Rent-Equipment & Vehicles											35
36	Other (specify):*											36
37	**TOTAL Ownership**			224,437	224,437		224,437	134,073	358,510			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers			8,254	8,254		8,254		8,254			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops			269	269		269		269			41
42	Provider Participation Fee			41,176	41,176		41,176		41,176			42
43	Other (specify):*							34,303	34,303			43
44	**TOTAL Special Cost Centers**			49,699	49,699		49,699	34,303	84,002			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	1,051,792	169,554	650,634	1,871,980		1,871,980	214,800	2,086,780			45

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

Facility Name & ID Number BIRCHWOOD NURSING HOME # 0040824 Report Period Beginning: 1/1/00 Ending: 12/31/00

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7. In column 2 below, reference the line on which the particular cost was included. (See instructions.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Reference	3 OHF USE ONLY	
1	Day Care	$		$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals	(1,100)	2		4
5	Telephone, TV & Radio in Resident Rooms	(1)	21		5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation				9
10	Interest and Other Investment Income				10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax				13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties				18
19	Entertainment				19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(7,439)	21		24
25	Fund Raising, Advertising and Promotional				25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	Nurse Aide Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule	85,276			29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ 76,736		$	30

OHF USE ONLY								
48		49		50		51		52	

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	138,064		34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ 138,064		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ 214,800		37

***These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.**

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)

		1 Yes	2 No	3 Amount	4 Reference	
38	Medically Necessary Transport.			$		38
39						39
40	Gift and Coffee Shops					40
41	Barber and Beauty Shops					41
42	Laboratory and Radiology					42
43	Prescription Drugs					43
44	Exceptional Care Program					44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	**TOTAL (C): (sum of lines 38-46)**			$		47

STATE OF ILLINOIS

BIRCHWOOD NURSING HOME

ID# 0040824

Report Period Beginning: 1/1/00

Ending: 12/31/00

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	SALES TAX	$ (1,204)	21	1
2	MEMORIUM/BENEVOLENCE EXPENSE	(404)	21	2
3	Depreciation Reconciliation	(21,193)	30	3
4	FAS 121 Impairment Charge**	104,964	30	4
5	Therapy Adjustment	5,811	10a	5
6	Out of State Travel	(2,698)	24	6
7				7
8	** The facility re-valued their assets in 1999. We			8
9	have reported the historical costs of the assets			9
10	consistent with the prior years, and have ensured			10
11	that depreciation expense is reported on straight			11
12	line. This adjustment is necessary to reverse the			12
13	re-valuation of historical cost.			13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32
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39				39
40				40
41				41
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71				71
72				72
73				73
74				74
75				75
76				76
77				77
78				78
79				79
80				80
81				81
82				82
83				83
84				84
85				85
86				86
87				87
88				88
89				89
90	**Total**	85,276		90

STATE OF ILLINOIS

Summary A

Facility Name & ID Number BIRCHWOOD NURSING HOME # 0040824 Report Period Beginning: 1/1/00 Ending: 12/31/00

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Operating Expenses	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	A. General Services													
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	(1,100)	0	0	0	0	0	0	0	0	0	0	(1,100)	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	0	0	0	0	0	0	0	0	0	0	0	0	5
6	Maintenance	0	219	0	0	0	0	0	0	0	0	0	219	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	**TOTAL General Services**	(1,100)	219	0	0	0	0	0	0	0	0	0	(881)	8
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	0	0	0	0	0	0	0	0	0	0	0	10
10a	Therapy	5,811	0	0	0	0	0	0	0	0	0	0	5,811	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	Nurse Aide Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	**TOTAL Health Care and Programs**	5,811	0	0	0	0	0	0	0	0	0	0	5,811	16
	C. General Administration													
17	Administrative	0	0	0	0	0	0	0	0	0	0	0	0	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	7,758	0	0	0	0	0	0	0	0	0	7,758	19
20	Fees, Subscriptions & Promotions	0	145	0	0	0	0	0	0	0	0	0	145	20
21	Clerical & General Office Expenses	(9,048)	43,196	0	0	0	0	0	0	0	0	0	34,148	21
22	Employee Benefits & Payroll Taxes	0	0	0	0	0	0	0	0	0	0	0	0	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	(2,698)	1,306	0	0	0	0	0	0	0	0	0	(1,392)	24
25	Other Admin. Staff Transportation	0	0	0	0	0	0	0	0	0	0	0	0	25
26	Insurance-Prop.Liab.Malpractice	0	835	0	0	0	0	0	0	0	0	0	835	26
27	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	27
28	**TOTAL General Administration**	(11,746)	53,240	0	0	0	0	0	0	0	0	0	41,494	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(7,035)	53,459	0	0	0	0	0	0	0	0	0	46,424	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number BIRCHWOOD NURSING HOME # 0040824 **Report Period Beginning:** 1/1/00 **Ending:** 12/31/00

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Capital Expense	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	D. Ownership													
30	Depreciation	83,771	0	0	0	0	0	0	0	0	0	0	83,771	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	0	20,661	0	0	0	0	0	0	0	0	0	20,661	32
33	Real Estate Taxes	0	0	0	0	0	0	0	0	0	0	0	0	33
34	Rent-Facility & Grounds	0	29,641	0	0	0	0	0	0	0	0	0	29,641	34
35	Rent-Equipment & Vehicles	0	0	0	0	0	0	0	0	0	0	0	0	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	**TOTAL Ownership**	83,771	50,302	0	0	0	0	0	0	0	0	0	134,073	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	0	0	0	0	0	0	0	0	0	0	0	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	0	34,303	0	0	0	0	0	0	0	0	0	34,303	43
44	**TOTAL Special Cost Centers**	0	34,303	0	0	0	0	0	0	0	0	0	34,303	44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	76,736	138,064	0	0	0	0	0	0	0	0	0	214,800	45

Facility Name & ID Number BIRCHWOOD NURSING HOME # 0040824 Report Period Beginning: 1/1/00 Ending: 12/31/00

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
Mariner Post Acute Network	100	See attached schedule		Mariner Post Acute	Atlanta, GA	Bkkpg & Mngmnt

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V	5	Utilities	$	Mariner Post Acute Network	100.00%	$ 0	$	1
2	V	6	Repairs and Maintenance		Mariner Post Acute Network	100.00%	219	219	2
3	V	19	Professional Services		Mariner Post Acute Network	100.00%	7,758	7,758	3
4	V	20	Fees, Subscriptions, Promotions		Mariner Post Acute Network	100.00%	145	145	4
5	V	21	Clerical and General Office Expense		Mariner Post Acute Network	100.00%	43,196	43,196	5
6	V	24	Travel and Seminar		Mariner Post Acute Network	100.00%	1,306	1,306	6
7	V	26	Insurance Premium		Mariner Post Acute Network	100.00%	835	835	7
8	V	32	Interest Expense		Mariner Post Acute Network	100.00%	20,661	20,661	8
9	V	34	Rental & Leasing		Mariner Post Acute Network	100.00%	29,641	29,641	9
10	V	43	Other Expenses		Mariner Post Acute Network	100.00%	34,303	34,303	10
11	V								11
12	V								12
13	V								13
14	Total			$			$ 138,064	$ * 138,064	14

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number BIRCHWOOD NURSING HOME # 0040824 Report Period Beginning: 1/1/00 Ending: 12/31/00

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1	2	3	4	5	6		7		8	
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		Compensation Included in Costs for this Reporting Period**		Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1									$		1
2											2
3											3
4	NOT APPLICABLE										4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	$		13

* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees). FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME, ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION

Facility Name & ID Number BIRCHWOOD NURSING HOME # 0040824 Report Period Beginning: 1/1/00 Ending: 12/31/00

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: Mariner Post Acute Network
Street Address: One Ravinia Dr, Suite 1500
City / State / Zip Code: Atlanta, GA 30346
Phone Number: (770) 379-8203
Fax Number: (770) 399-1971

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	5	Utilities	Facility Costs			$ 212,153	$		$ 0	1
2	6	Repairs and Maintenance	Facility Costs			1,115,193			219	2
3	19	Professional Services	Facility Costs			19,156,199			7,758	3
4	20	Fees, Subscriptions, Promotions	Facility Costs			352,775			145	4
5	21	Clerical and General Office Exper	Facility Costs			51,126,150			43,196	5
6	24	Travel and Seminar	Facility Costs			5,661,045			1,306	6
7	26	Insurance Premium	Facility Costs			9,082,939			835	7
8	32	Interest Expense	Facility Costs			31,744,386			20,661	8
9	34	Rental & Leasing	Facility Costs			60,829,914			29,641	9
10	43	Other Expenses	Facility Costs			8,511,848			34,303	10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 187,792,602	$		$ 138,064	25

Facility Name & ID Number BIRCHWOOD NURSING HOME # 0040824 Report Period Beginning: 1/1/00 Ending: 12/31/00

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related** YES	Related** NO	Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note Original	Amount of Note Balance	Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
	A. Directly Facility Related Long-Term											
1	HEALTH CARE CAPITAL FINANCI	X		REFINANCE	$17,785.00	5/10/95	$ 1,830,000	$ 1,719,741	02/10/02	0.1072	$ 189,605	1
2												2
3												3
4												4
5												5
	Working Capital											
6	HOME OFFICE ALLOCATION										20,661	6
7												7
8												8
9	TOTAL Facility Related				$17,785.00		$ 1,830,000	$ 1,719,741			$ 210,266	9
	B. Non-Facility Related*											
10												10
11												11
12												12
13												13
14	TOTAL Non-Facility Related						$	$			$	14
15	TOTALS (line 9+line14)						$ 1,830,000	$ 1,719,741			$ 210,266	15

* Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7. (See instructions.)

** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2. (See instructions.)

Facility Name & ID Number BIRCHWOOD NURSING HOME # 0040824 Report Period Beginning: 1/1/00 Ending: 12/31/00

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)

B. Real Estate Taxes

1. Real Estate Tax accrual used on 1999 report.	$	17,628	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)	$	28,612	2
3. Under or (over) accrual (line 2 minus line 1).	$	10,984	3
4. Real Estate Tax accrual used for 2000 report. (Detail and explain your calculation of this accrual on the lines below.)	$	5,122	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. (Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)	$		5
6. Subtract a refund of real estate taxes used previously to calculate a payment rate. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. TOTAL REFUND $ For 19 Tax Year. (Attach a copy of the real estate tax appeal board's decision.)	$		6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.	$	16,106	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:			
	1995	14,693	8
	1996	15,184	9
	1997	15,075	10
	1998	16,394	11
	1999	28,612	12

2000 Tax Accrual $5,122

FOR OHF USE ONLY

13	FROM R. E. TAX STATEMENT FOR 1999	$	13
14	PLUS APPEAL COST FROM LINE 5	$	14
15	LESS REFUND FROM LINE 6	$	15
16	AMOUNT TO USE FOR RATE CALCULATION	$	16

NOTES:

1. **Please indicate a negative number by use of brackets( ). Deduct any overaccrual of taxes from prior year.**
2. **If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.**
   This denial must be no more than four years old at the time the cost report is filed.

Facility Name & ID Number BIRCHWOOD NURSING HOME # 0040824 Report Period Beginning: 1/1/00 Ending: 12/31/00

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 20,200 B. General Construction Type: Exterior MASONRY Frame STEEL Number of Stories 1

C. Does the Operating Entity? [X] (a) Own the Facility [ ] (b) Rent from a Related Organization. [ ] (c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity? [X] (a) Own the Equipment [ ] (b) Rent equipment from a Related Organization. [X] (c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, nurse aide training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable).

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? [ ] YES [X] NO
If so, please complete the following:

1. Total Amount Incurred: 2. Number of Years Over Which it is Being Amortized:

3. Current Period Amortization: 4. Dates Incurred:

Nature of Costs:
(Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

A. Land.

	1 Use	2 Square Feet	3 Year Acquired	4 Cost	
1	FACILITY	225,000	1994	$ 25,565	1
2	FACILITY		1994	2,360	2
3	TOTALS	225,000		$ 27,925	3

Facility Name & ID Number BIRCHWOOD NURSING HOME # 0040824 Report Period Beginning: 1/1/00 Ending: 12/31/00

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	75		1994	1972	$ 1,656,580	$ 47,331	35	$ 47,331	$ (0)	$ 310,939	4
5				1994	8,777	439	20	439		2,883	5
6											6
7											7
8											8
	Improvement Type**										
9											9
10											10
11	Canopy Cover			1994	1,465	73	20	73		380	11
12	A/C Project			1994	7,276	364	20	364		1,992	12
13	Building Improvement Acquisition			1995	153,814	7,691	20	7,691		42,834	13
14	Ceramic Tile			1996	5,798	290	20	290		1,020	14
15	Paint/Carpet			1996	8,681	434	20	434		1,491	15
16	Painting			1996	3,564	178	20	178		575	16
17	Plumbing - Pipes			1996	1,195	120	20	60	(60)	310	17
18	Water Heater			1996	3,533	353	20	177	(176)	825	18
19	Drapes			1996	179	18	20	9	(9)	38	19
20	Architect Services			1997	822	41	20	41		106	20
21	Flooring			1997	6,319	316	20	316		684	21
22	Feasibility Study			1997	2,945	147	20	147		318	22
23	Bathroom Tile			1997	656	3	20	33	30	71	23
24	Flooring			1997	828	83	20	41	(42)	162	24
25	Waterline			1997	507	51	20	25	(26)	93	25
26	Smoke Detector			1997	475	48	20	24	(24)	71	26
27	Water Softener			1997	4,881	488	20	244	(244)	975	27
28	Rooftop A/C			1997	3,601	60	20	180	120	565	28
29	Pluming			1997	3,061	306	20	153	(153)	480	29
30	Water Heater Repair			1997	516	52	20	26	(26)	60	30
31	Fire Alarm System			1998	626	31	20	31		62	31
32	HVAC			1998	2,146	107	20	107		214	32
33	Reconciling Adjustment to WTB 1998			1998		58,955			(58,955)		33
34											34
35											35
36	TOTAL (lines 4 thru 35)				$ 1,878,245	$ 117,979		$ 58,414	$ (59,565)	$ 367,148	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number BIRCHWOOD NURSING HOME # 0040824 Report Period Beginning: 1/1/00 Ending: 12/31/00

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4					$	$		$	$	$	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	Bradford 100 Gal Water Heater			1999	3,121	312	10	312		624	9
10	Move all Water Pipes			1999	35,000	1,167	25	1,167		2,334	10
11	Major Plumbing Install			1999	11,532	384	25	384		768	11
12	Install Water Lines			1999	13,998	373	25	373		746	12
13											13
14	Roof Replaced - first half			2000	57,500	479	10	479		479	14
15	Automatic 24-Hour Timer			2000	174	1	10	1		1	15
16	Installation Charge W/G System			2000	5,480	46	10	46		46	16
17	Cr Maglock Single Door			2000	(691)	(6)	10	(6)		(6)	17
18	Repl:Generator			2000	10,000	56	15	56		56	18
19	Back Door Wiring Repair			2000	129	1	10	1		1	19
20	Rehook Elec & Outlet-Gen Panel			2000	277	2	10	2		2	20
21	Hooking Up Door Alarms			2000	291	2	10	2		2	21
22	Hooking Up Outlets for Dooralarm			2000	342	3	10	3		3	22
23	Roof Replacement - second half			2000	68,250	569	10	569		569	23
24	Sidewalks, Center Courtyard			2000	1,150	6	15	6		6	24
25											25
26											26
27											27
28											28
29											29
30											30
31											31
32											32
33											33
34											34
35											35
36	TOTAL (lines 4 thru 35)				$ 206,553	$ 3,395		$ 3,395	$	$ 5,631	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number BIRCHWOOD NURSING HOME # 0040824 Report Period Beginning: 1/1/00 Ending: 12/31/00

XI. OWNERSHIP COSTS (continued)

C. Equipment Depreciation-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
37	Purchased in Prior Years	$ 403,563	$ 40,356	$ 40,356	$		$ 235,464	37
38	Current Year Purchases	10,876	208	208			208	38
39	Fully Depreciated Assets							39
40								40
41	TOTALS	$ 414,439	$ 40,564	$ 40,564	$		$ 235,672	41

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
42				$	$	$	$		$	42
43										43
44										44
45										45
46	TOTALS			$	$	$	$		$	46

E. Summary of Care-Related Assets

		1 Reference	2 Amount	
47	Total Historical Cost	(line 3,col.4 + line 36,col.4 + line 41,col.1 + line 46,col.4)	$ 2,527,162	47
48	Current Book Depreciation	(line 36,col.5 + line 41,col.2 + line 46,col.5)	$ 161,938	48
49	Straight Line Depreciation	(line 36,col.7 + line 41,col.3 + line 46,col.6)	$ 102,373	49 **
50	Adjustments	(line 36,col.8 + line 41,col.4 + line 46,col.7)	$ (59,565)	50
51	Accumulated Depreciation	(line 36,col.9 + line 41,col.6 + line 46,col.9)	$ 608,451	51

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
52	OVERHEAD ALLOCATION - 1996	$ 5,605	$ 281	$ 952	52
53	OVERHEAD ALLOCATION - 1997	1,323	66	156	53
54					54
55					55
56					56
57	TOTALS	$ 6,928	$ 347	$ 1,108	57

G. Construction-in-Progress

	Description	Cost	
58		$	58
59			59
60			60
61		$	61

* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

** This must agree with Schedule V line 30, column 8.

Facility Name & ID Number BIRCHWOOD NURSING HOME # 0040824 Report Period Beginning: 1/1/00 Ending: 12/31/00

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease:
2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?
   If NO, see instructions. ☐ YES ☐ NO

		1 Year Constructed	2 Number of Beds	3 Date of Lease	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				$			3
4	Additions							4
5								5
6								6
7	TOTAL				$ **			7

8. List separately any amortization of lease expense included on page 4, line 34.
   This amount was calculated by dividing the total amount to be amortized
   by the length of the lease .

9. Option to Buy: ☐ YES ☐ NO Terms: *

10. Effective dates of current rental agreement:
    Beginning
    Ending

11. Rent to be paid in future years under the current rental agreement:

	Fiscal Year Ending	Annual Rent
12.	/2001	$
13.	/2002	$
14.	/2003	$

B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental? ☐ YES ☐ NO
16. Rental Amount for movable equipment: $ 0 Description:
    (Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17			$	$	17
18					18
19					19
20					20
21	TOTAL		$	$	21

* If there is an option to buy the building, please provide complete details on attached schedule.

** This amount plus any amortization of lease expense must agree with page 4, line 34.

Facility Name & ID Number BIRCHWOOD NURSING HOME # 0040824 Report Period Beginning: 1/1/00 Ending: 12/31/00

XIII. EXPENSES RELATING TO NURSE AIDE TRAINING PROGRAMS (See instructions.)

A. TYPE OF TRAINING PROGRAM (If aides are trained in another facility program, attach a schedule listing the facility name, address and cost per aide trained in that facility.)

1. HAVE YOU TRAINED AIDES DURING THIS REPORT PERIOD? [ ] YES [X] NO

If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.

2. CLASSROOM PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - COMMUNITY COLLEGE [ ]
   - HOURS PER AIDE ____

3. CLINICAL PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - HOURS PER AIDE ____

B. EXPENSES

ALLOCATION OF COSTS (d)

		1	2	3	4
		Facility			
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	$	$	$	$
2	Books and Supplies				
3	Classroom Wages (a)				
4	Clinical Wages (b)				
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments				
8	Nurse Aide Competency Tests				
9	TOTALS	$	$	$	$
10	SUM OF line 9, col. 1 and 2 (e)	$			

C. CONTRACTUAL INCOME

In the box below record the amount of income your facility received training aides from other facilities.

$

D. NUMBER OF AIDES TRAINED

COMPLETED	
1. From this facility	
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	

(a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
(c) For in-house training programs only. Do not include fringe benefits.
(d) Allocate based on if the aide is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own aides.
(e) The total amount of Drop-out and Completed Costs for your own aides must agree with Sch. V, line 13, col. 8.
(f) Attach a schedule of the facility names and addresses of those facilities for which you trained aides.

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)

	1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist		hrs	$		$	$		$	1
2	Licensed Speech and Language Development Therapist		hrs							2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist		hrs							4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy		# of prescrpts				8,100		8,100	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program									12
13	Other (specify): Audiologist						154		154	13
14	TOTAL			$		$	$ 8,254		$ 8,254	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as nurse aides, who help with the above activities should not be listed on this schedule.

Facility Name & ID Number BIRCHWOOD NURSING HOME **#** 0040824 **Report Period Beginning:** 1/1/00 **Ending:** 12/31/00

XV. BALANCE SHEET - Unrestricted Operating Fund. **As of** 12/31/00 **(last day of reporting year)**

This report must be completed even if financial statements are attached.

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	$ 900	$	1
2	Cash-Patient Deposits	3,780		2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	185,820		3
4	Supply Inventory (priced at)	11,022		4
5	Short-Term Investments			5
6	Prepaid Insurance			6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):			9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 201,522	$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land	275,024		13
14	Buildings, at Historical Cost	1,055,021		14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost	104,120		16
17	Accumulated Depreciation (book methods)	(388,472)		17
18	Deferred Charges	54,000		18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify):			23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 1,099,693	$	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 1,301,215	$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 275,001	$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	92,784		30
31	Accrued Taxes Payable (excluding real estate taxes)	11,056		31
32	Accrued Real Estate Taxes(Sch.IX-B)	5,122		32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	SEE ATTACHED SCHEDULE	136,547		36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 520,510	$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43	SEE ATTACHED SCHEDULE	3,817,915		43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$ 3,817,915	$	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 4,338,425	$	46
47	**TOTAL EQUITY(page 18, line 24)**	$ (3,037,210)	$	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 1,301,215	$	48

***(See instructions.)**

Facility Name & ID Number BIRCHWOOD NURSING HOME # 0040824 Report Period Beginning: 1/1/00 Ending: 12/31/00

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ (3,163,550)	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ (3,163,550)	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	133,443	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	( )	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	**TOTAL Additions (deductions) (sum of lines 7-16)**	$ 133,443	17
	B. Transfers (Itemize):		
18	INTERCOMPANY TRANSFERS	(7,103)	18
19			19
20			20
21			21
22			22
23	**TOTAL Transfers (sum of lines 18-22)**	$ (7,103)	23
24	**BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)**	$ (3,037,210)	24 *

*** This must agree with page 17, line 47.**

Facility Name & ID Number BIRCHWOOD NURSING HOME # 0040824 Report Period Beginning: 1/1/00 Ending: 12/31/00

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.

Note: This schedule should show gross revenue and expenses. Do not net revenue against expense.

	Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 2,338,971	1
2	Discounts and Allowances for all Levels	(343,631)	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 1,995,340	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy		6
7	Oxygen		7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	Nurses Aide Training Reimbursements		11
12	Gift and Coffee Shop	50	12
13	Barber and Beauty Care	1,100	13
14	Non-Patient Meals	1	14
15	Telephone, Television and Radio		15
16	Rental of Facility Space	50	16
17	Sale of Drugs		17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services	1,805	21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 3,006	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***		25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$	26
	E. Other Revenue (specify):**		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	VENDING MACHINE		28
28a	MISCELLANEOUS RECEIPTS	(27)	28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ (27)	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 1,998,319	30

	Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	435,439	31
32	Health Care	788,472	32
33	General Administration	373,932	33
	B. Capital Expense		
34	Ownership	224,438	34
	C. Ancillary Expense		
35	Special Cost Centers	8,523	35
36	Provider Participation Fee	41,176	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 1,871,980	40
41	**Income before Income Taxes (line 30 minus line 40)****	126,339	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ 126,339	43

* **This must agree with page 4, line 45, column 4.**

** **Does this agree with taxable income (loss) per Federal Income Tax Return? _____ If not, please attach a reconciliation.**

*** **See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation.**

**** **Provide a detailed breakdown of "Other Revenue" on an attached sheet.**

Facility Name & ID Number BIRCHWOOD NURSING HOME # 0040824 Report Period Beginning: 1/1/00 Ending: 12/31/00

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)
(This schedule must cover the entire reporting period.)

		1 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing	1,987	2,109	$ 41,096	$ 19.49	1
2	Assistant Director of Nursing	1,995	2,118	36,198	17.09	2
3	Registered Nurses	4,711	5,001	77,486	15.49	3
4	Licensed Practical Nurses	14,546	15,441	203,701	13.19	4
5	Nurse Aides & Orderlies	33,302	35,350	320,846	9.08	5
6	Nurse Aide Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director	2,006	2,129	21,408	10.06	9
10	Activity Assistants	720	764	5,533	7.24	10
11	Social Service Workers	1,985	2,107	23,460	11.13	11
12	Dietician					12
13	Food Service Supervisor	1,867	1,982	25,122	12.68	13
14	Head Cook	4,689	4,978	34,288	6.89	14
15	Cook Helpers/Assistants	5,975	6,343	38,940	6.14	15
16	Dishwashers					16
17	Maintenance Workers	2,412	2,560	27,934	10.91	17
18	Housekeepers	9,840	10,445	74,192	7.10	18
19	Laundry	3,783	4,016	24,348	6.06	19
20	Administrator	1,958	2,078	51,158	24.62	20
21	Assistant Administrator					21
22	Other Administrative	1,850	1,963	30,056	15.31	22
23	Office Manager					23
24	Clerical	55	58	1,213	20.91	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	1,453	1,542	14,813	9.61	31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	95,134	100,984	$ 1,051,792 *	$ 10.42	34

* This total must agree with page 4, column 1, line 45.

** See instructions.

B. CONSULTANT SERVICES

		1 Number of Hrs. Paid & Accrued	2 Total Consultant Cost for Reporting Period	3 Schedule V Line & Column Reference	
35	Dietary Consultant	189	$ 7,274	1-3	35
36	Medical Director				36
37	Medical Records Consultant				37
38	Nurse Consultant				38
39	Pharmacist Consultant				39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant				44
45	Social Service Consultant	96	4,245	12-3	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	285	$ 11,519		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 Schedule V Line & Column Reference	
50	Registered Nurses		$		50
51	Licensed Practical Nurses				51
52	Nurse Aides				52
53	TOTAL (lines 50 - 52)		$		53

Facility Name & ID Number BIRCHWOOD NURSING HOME # 0040824 Report Period Beginning: 1/1/00 Ending: 12/31/00

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Carol West	Administrator	0	$ 62,317
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 62,317

B. Administrative - Other

Description	Amount
	$
TOTAL (agree to Schedule V, line 17, col. 3)	$
(Attach a copy of any management service agreement)	

C. Professional Services

Vendor/Payee	Type	Amount
See attached	Legal Fees	$ 4,526
TOTAL (agree to Schedule V, line 19, column 3)		
(If total legal fees exceed $2500 attach copy of invoices.)		$ 4,526

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 18,310
Unemployment Compensation Insurance	13,562
FICA Taxes	77,682
Employee Health Insurance	35,301
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	
OTHER EMPLOYEE BENEFITS	9,946
TOTAL (agree to Schedule V, line 22, col.8)	$ 154,801

E. Schedule of Non-Cash Compensation Paid to Owners or Employees

Description	Line #	Amount
		$
TOTAL		$

* Attach copy of IMRF notifications

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$ 323
Advertising: Employee Recruitment	
Health Care Worker Background Check	
(Indicate # of checks performed)	
DUES	3,540
HOME OFFICE ALLOCATION	145
SUBSCRIPTIONS	200
Less: Public Relations Expense	( )
Non-allowable advertising	( )
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 4,208

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$ 2,698
In-State Travel	5,057
HOME OFFICE ALLOCATION	1,306
Seminar Expense	400
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 9,461

**See instructions.

Facility Name & ID Number BIRCHWOOD NURSING HOME # 0040824 Report Period Beginning: 1/1/00 Ending: 12/31/00

XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).
(See instructions.)

	1	2	3	4	5	6	7	8	9	10	11	12	13
	Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	Amount of Expense Amortized Per Year								
					FY1997	FY1998	FY1999	FY2000	FY2001	FY2002	FY2003	FY2004	FY2005
1			$		$	$	$	$	$	$	$	$	$
2													
3													
4													
5													
6													
7													
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		$		$	$	$	$	$	$	$	$	$

Facility Name & ID Number BIRCHWOOD NURSING HOME # 0040824 **Report Period Beginning:** 1/1/00 **Ending:** 12/31/00

XX. GENERAL INFORMATION:

(1) Are nursing employees (RN,LPN,NA) represented by a union? **No**

(2) Are there any dues to nursing home associations included on the cost report? **Yes**
If YES, give association name and amount. **Illinois Health Care Association - $4,218**

(3) Did the nursing home make political contributions or payments to a political action organization? **No** If YES, have these costs been properly adjusted out of the cost report? **N/A**

(4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? **No** If YES, what is the capacity? **N/A**

(5) Have you properly capitalized all major repairs and equipment purchases? **YES**
What was the average life used for new equipment added during this period? **21**

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. $ **N/A** Line **N/A**

(7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? **YES** If NO, attach a complete explanation.

(8) Are you presently operating under a sale and leaseback arrangement? **NO**
If YES, give effective date of lease. **N/A**

(9) Are you presently operating under a sublease agreement? YES **X** NO

(10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES NO If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.
N/A

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department of Public Aid during this cost report period. $ **41,176**
This amount is to be recorded on line 42 of Schedule V.

(12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? **NO** If YES, attach an explanation of the allocation.

(13) Have costs for all supplies and services which are of the type that can be billed to the Department of Public Aid, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? **N/A**

(14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? **No** For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.

(15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. $ Has any meal income been offset against related costs? **YES** Indicate the amount. $ **1,100**

(16) Travel and Transportation
a. Are there costs included for out-of-state travel? **NO**
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? **NO** If YES, please indicate the amount of income earned from such a program during this reporting period. $ **N/A**
c. What percent of all travel expense relates to transportation of nurses and patients? **75%**
d. Have vehicle usage logs been maintained? **N/A**
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? **N/A**
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? **N/A**
g. Does the facility transport residents to and from day training? NO
Indicate the amount of income earned from providing such transportation during this reporting period. $ **N/A**

(17) Has an audit been performed by an independent certified public accounting firm? **NO**
Firm Name: **N/A** The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? **N/A** If no, please explain. **N/A**

(18) Have all costs which do not relate to the provision of long term care been adjusted out out of Schedule V? **YES**

(19) If total legal fees are in excess of $2500, have legal invoices and a summary of services performed been attached to this cost report? **YES**
Attach invoices and a summary of services for all architect and appraisal fees.